APPENDIX F

FORMS

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
EMERGENCY CARE DATA RECORD
MANUAL ABSTRACT REPORTING FORM

For use with encounter visits on or after October 1, 2004

Instructions: For a description of the data elements, refer to the appropriate section of the Patient Data Reporting Requirements (Title 22, Sections 97251 through 97265)

A. FACILITY ID NUMBER

B. ABSTRACT RECORD NUMBER (Optional)

1. DATE OF BIRTH

Month Day Year (4-digit)
M M D D C C Y Y

2. SEX
F Female
M Male
U Unknown

3. RACE
R1 American Indian or Alaska Native
R2 Asian
R3 Black or African American
R4 Native Hawaiian or Other Pacific Islander
R5 White
R9 Other Race
99 Unknown

4. ETHNICITY
E1 Hispanic or Latino
E2 Non-Hispanic or Non-Latino
99 Unknown

5. ZIP CODE

99999 = Unknown

6. PATIENT'S SOCIAL SECURITY NUMBER

Report 000000001(Unknown) **if not recorded in the patient's medical record**

7. SERVICE DATE

Month Day Year (4-digit)
M M D D C C Y Y

8. PRINCIPAL DIAGNOSIS
ICD-9-CM CODE

9. OTHER DIAGNOSES
ICD-9-CM CODE
a.
b.
c.
d.
e.
f.
g.
h.
i.
j.

10. PRINCIPAL E-CODE
ICD-9-CM CODE
E

11. OTHER E-CODES
ICD-9-CM CODE
a. E
b. E
c. E
d. E

12. PRINCIPAL PROCEDURE
CPT-4 CODE

13. OTHER PROCEDURES
CPT-4 CODE
a.
b.
c.
d.
e.
f.
g.
h.
i.
j.

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
EMERGENCY CARE DATA RECORD
MANUAL ABSTRACT REPORTING FORM
For use with encounter visits on or after October 1, 2004

A. FACILITY ID NUMBER

B. ABSTRACT RECORD NUMBER (Optional)

1. DATE OF BIRTH (MMDDCCYY)

7. SERVICE DATE (MMDDCCYY)

9. OTHER DIAGNOSES
ICD-9-CM CODE

k.
l.
m.
n.
o.
p.
q.
r.
s.
t.
u.
v.
w.
x.

13. OTHER PROCEDURES
CPT-4 CODE

k.
l.
m.
n.
o.
p.
q.
r.
s.
t.

14. DISPOSITION OF PATIENT

01 Discharged to home or self care (routine discharge)
02 Discharged/transferred to a short term general hospital for inpatient care
03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification
04 Discharged/transferred to an intermediate care facility (ICF)
05 Discharged/transferred to a non-Medicare PPS children's hospital or non-Medicare PPS cancer hospital for inpatient care
06 Discharged/transferred to home under care of organized home health service organization
07 Left against medical advice or discontinued care
08 Discharged/transferred to home under care of a Home Intravenous (IV) provider
20 Expired
43 Discharged/transferred to a federal health care facility
50 Discharged home with hospice care
51 Discharged to a medical facility with hospice care
61 Discharged/transferred to a hospital-based Medicare approved swing bed
62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital
63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
00 Other

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
EMERGENCY CARE DATA RECORD
MANUAL ABSTRACT REPORTING FORM

For use with encounter visits on or after October 1, 2004

A. FACILITY ID NUMBER | **B. ABSTRACT RECORD NUMBER (Optional)** | **1. DATE OF BIRTH** (MMDDCCYY) | **7. SERVICE DATE** (MMDDCCYY)

15. EXPECTED SOURCE OF PAYMENT

09 Self Pay
11 Other Non-federal programs
12 Preferred Provider Organization (PPO)
13 Point of Service (POS)
14 Exclusive Provider Organization (EPO)
16 Health Maintenance Organization (HMO) Medicare Risk
AM Automobile Medical
BL Blue Cross/Blue Shield
CH CHAMPUS (TRICARE)
CI Commercial Insurance Company
DS Disability
HM Health Maintenance Organization
MA Medicare Part A
MB Medicare Part B
MC Medicaid (Medi-Cal)
OF Other federal program
TV Title V
VA Veterans Affairs Plan
WC Workers' Compensation Health Claim
00 Other

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
AMBULATORY SURGERY DATA RECORD
MANUAL ABSTRACT REPORTING FORM

For use with encounter visits on or after October 1, 2004

Instructions: For a description of the data elements, refer to the appropriate section of the Patient Data Reporting Requirements (Title 22, Sections 97251 through 97265)

A. FACILITY ID NUMBER

B. ABSTRACT RECORD NUMBER (Optional)

1. DATE OF BIRTH

Month Day Year (4-digit)
M M D D C C Y Y

2. SEX
F Female
M Male
U Unknown

3. RACE
R1 American Indian or Alaska Native
R2 Asian
R3 Black or African American
R4 Native Hawaiian or Other Pacific Islander
R5 White
R9 Other Race
99 Unknown

4. ETHNICITY
E1 Hispanic or Latino
E2 Non-Hispanic or Non-Latino
99 Unknown

5. ZIP CODE

99999 = Unknown

6. PATIENT'S SOCIAL SECURITY NUMBER

Report 000000001(Unknown) **if not recorded in the patient's medical record**

7. SERVICE DATE

Month Day Year (4-digit)
M M D D C C Y Y

8. PRINCIPAL DIAGNOSIS
ICD-9-CM CODE

9. OTHER DIAGNOSES
ICD-9-CM CODE
a.
b.
c.
d.
e.
f.
g.
h.
i.
j.

10. PRINCIPAL E-CODE
ICD-9-CM CODE
E

11. OTHER E-CODES
ICD-9-CM CODE
a. E
b. E
c. E
d. E

12. PRINCIPAL PROCEDURE
CPT-4 CODE

13. OTHER PROCEDURES
CPT-4 CODE
a.
b.
c.
d.
e.
f.
g.
h.
i.
j.

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
AMBULATORY SURGERY DATA RECORD
MANUAL ABSTRACT REPORTING FORM
For use with encounter visits on or after October 1, 2004

A. FACILITY ID NUMBER | **B. ABSTRACT RECORD NUMBER (Optional)** | **1. DATE OF BIRTH** (MMDDCCYY)

7. SERVICE DATE (MMDDCCYY)

9. OTHER DIAGNOSES
ICD-9-CM CODE

k.
l.
m.
n.
o.
p.
q.
r.
s.
t.
u.
v.
w.
x.

13. OTHER PROCEDURES
CPT-4 CODE

k.
l.
m.
n.
o.
p.
q.
r.
s.
t.

14. DISPOSITION OF PATIENT

01 Discharged to home or self care (routine discharge)
02 Discharged/transferred to a short term general hospital for inpatient care
03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification
04 Discharged/transferred to an intermediate care facility (ICF)
05 Discharged/transferred to a non-Medicare PPS children's hospital or non-Medicare PPS cancer hospital for inpatient care
06 Discharged/transferred to home under care of organized home health service organization
07 Left against medical advice or discontinued care
08 Discharged/transferred to home under care of a Home Intravenous (IV) provider
20 Expired
43 Discharged/transferred to a federal health care facility
50 Discharged home with hospice care
51 Discharged to a medical facility with hospice care
61 Discharged/transferred to a hospital-based Medicare approved swing bed
62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital
63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
00 Other

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
AMBULATORY SURGERY DATA RECORD
MANUAL ABSTRACT REPORTING FORM

For use with encounter visits on or after October 1, 2004

A. FACILITY ID NUMBER | | | | | | |

B. ABSTRACT RECORD NUMBER (Optional) | | | | | | | | | | | |

1. DATE OF BIRTH (MMDDCCYY) | | | | | | | | |

7. SERVICE DATE (MMDDCCYY) | | | | | | | | |

15. EXPECTED SOURCE OF PAYMENT

| | |

09 Self Pay
11 Other Non-federal programs
12 Preferred Provider Organization (PPO)
13 Point of Service (POS)
14 Exclusive Provider Organization (EPO)
16 Health Maintenance Organization (HMO) Medicare Risk
AM Automobile Medical
BL Blue Cross/Blue Shield
CH CHAMPUS (TRICARE)
CI Commercial Insurance Company
DS Disability
HM Health Maintenance Organization
MA Medicare Part A
MB Medicare Part B
MC Medicaid (Medi-Cal)
OF Other federal program
TV Title V
VA Veterans Affairs Plan
WC Workers' Compensation Health Claim
00 Other

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

PATIENT DATA

INDIVIDUAL FACILITY TRANSMITTAL FORM

OSHPD Use Only
PM Date: _____
Agent: _____

Facility Name: _____

Facility Identification Number: | | | | | | |

Report Period From: _____ to _____

Total Number of Records: _____

DISKETTE

( ) 3½" Diskette

( ) CD-ROM

Filename:

_____

CERTIFICATION

I, _____, certify under penalty of perjury as follows:
(Name of Individual)

That I am an official of _____ and am duly
(Name of Facility)

authorized to sign this certification; and that, to the extent of my knowledge and information, the accompanying records are true and correct, and that the definitions of the required data elements in Subsection (g) of Section 128735, or Subsection (a) of Section 128736, or Subsection (a) of Section 128737 of the Health and Safety Code, as set forth in the California Code of Regulations, have been followed by this facility.

Dated: _____ By: _____
(Signature)

Facility: _____ Name: _____
(Please Print)

Address: _____ Title: _____

_____ Phone: _____

E-mail: _____

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

PATIENT DATA

AGENT'S TRANSMITTAL FORM

OSHPD Use Only
PM Date: _____
Agent: _____

Agent's Name: _____

Contact Person: _____ Title: _____

Address: _____

Phone No: ( ) _____ Ext: _____

E-mail _____

DISKETTE

( ) 3½" Diskette

( ) CD-ROM

Filename:

_____

	FACILITY NAME	FAC. ID NO	REPORT PERIOD BEGINNING	REPORT PERIOD ENDING	TOTAL NO OF RECORDS
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
HEALTHCARE INFORMATION DIVISION
PATIENT DISCHARGE DATA SECTION
818 K Street, Room 100
Sacramento, California 95814
(916) 323-7679 FAX (916) 327-1262

Agent Designation Form

Facilities must complete this form in order to designate a third party agent to submit data on their behalf. All information must be provided, including a signature from a facility administrator or primary contact.

Please print clearly

Section 1: Facility Information *(all information is required)*

1. **FACILITY NUMBER :**	2. **FACILITY NAME:**
3. **FACILITY BUSINESS ADDRESS (MAILING ADDRESS):**	
4. **FACILITY CONTACT NAME:**	5. **TITLE:**
6. **PHONE:**	7. **E-MAIL ADDRESS:**

Section 2: Designated Agent Information *(all information is required)*

8. **NAME OF DESIGNATED AGENT (COMPANY NAME):**	
9. **BUSINESS ADDRESS (MAILING ADDRESS):**	
10. **CONTACT NAME:**	
11. **PHONE:**	12. **E-MAIL ADDRESS:**
DESIGNATION EFFECTIVE DATE	
13. **EFFECTIVE BEGIN DATE:**	**Designation is effective until OSHPD receives written notification of revocation or new designation.**

By signing this document, I certify that I am an official of my facility and that I am approving the aforementioned Designated Agent to submit data on behalf of my facility for the designated effective dates.

14. **NAME (PRINT):**	15. **TITLE:**
16. **SIGNATURE:**	17. **DATE:**

MIRCal
Medical Information Reporting for California

Instructions for Completing the MIRCal Designated Agent User Registration Package

To access the Office of Statewide Health Planning and Development's (OSHPD) Medical Information Reporting System for California (MIRCal), all potential users at your Designated Agent facility must first complete and submit a completed MIRCal Designated Agent User Agreement.

It is the responsibility of the **primary** Designated Agent contact to read these instructions and return the completed MIRCal Designated Agent User Agreement to OSHPD for each MIRCal user within their facility. Please complete the following steps to register for MIRCal:

1. Determine who your MIRCal users will be.

    - Each Designated Agent may designate as many as three MIRCal users.
    - Designated Agents will have access to submit and retrieve the status of data submissions through MIRCal but will ***not*** have access to make corrections to data on the behalf of hospitals.

2. Once the MIRCal users are determined, read and complete the MIRCal Designated Agent User Agreement for each MIRCal user within your facility. Make additional copies if necessary.

4. The primary Designated Agent contact must sign and approve the agreements.

5. Make a copy of the completed forms for your records. Mail the original to:

Office of Statewide Health Planning and Development
Patient Discharge Data Section
818 K Street, Room 100
Sacramento, CA 95814

Contact Information
Phone (916) 324-6147
Fax (916) 322-9555
E-mail mircal@oshpd.state.ca.us

The original must be sent and received before OSHPD can complete the processing of your forms.

Upon receipt and verification of these forms, OSHPD will confirm your enrollment by phone and provide you with MIRCal user IDs, passwords and the web-site address for MIRCal Data Submission.

The Hospital Administrator at each facility you represent must complete and sign the Agent Designation and Certification Form (OSHPD 1370.3) approving your company to submit data on their behalf. Usernames and passwords will not be assigned to a Designated Agent until this form is completed, signed and returned to OSHPD.

PATIENT DATA REPORTING
EXTENSION REQUEST

To: Office of Statewide Health Planning and Development
Patient Data Section
818 K Street, Room 100
Sacramento, CA 95814
www.oshpd.ca.gov/mircal
(916) 323-7679
Fax No. (916) 322-9555
Fax No. (916) 327-1262

Date:_____

ATTN: Patient Data Section

1. Facility Name (DBA): _____
2. Address: _____
3. Mailing Address (if different): _____
4. Facility Identification Number: _____
5. Report Period Beginning Date: _____
6. Report Period Ending Date: _____
7. Designated Agent (if applicable): _____
8. Number of Days of Extension Request: _____
9. Justification: (Include the actions taken to produce the data by the required deadline and those factors which prevent submission of the data by the deadline, and those actions to be taken and the time needed to accommodate them):

_____

_____

_____

_____

_____

_____

10. Person Requesting Extension (print): _____
11. Signature: _____
12. Title: _____
13. Phone:_____ E-mail:_____

Facility User Account Administrator Agreement

Please print clearly

Section 1: MIRCal User Account Administrator Information *(all information is required)*

1. FACILITY NUMBER:	**2. FACILITY NAME:**
3. NAME (FIRST, MIDDLE INITIAL, LAST):	
4. BUSINESS ADDRESS (MAILING ADDRESS):	**5. UNIQUE EMPLOYEE IDENTIFIER:** ***Note: An identifier that uniquely distinguishes you within your organization.***
6. BUSINESS PHONE:	**7. BUSINESS FAX:**
8. E-MAIL ADDRESS:	
9. AUTHENTICATION WORDS: *Remember these words, you may be asked to identify yourself with this information if you call to reset your password.*	
a. ***Your mother's maiden name:***	**b.** ***Your city of birth:***

I understand that as an appointed MIRCal User Account Administrator on behalf of the hospital, I have the responsibility to:

1. Create/add and delete user accounts for other MIRCal users within my facility. Creating a user account grants access for an individual to read, submit and correct my facility's confidential data. Deleting user accounts revokes this access.
2. Modify the demographic information for my facility's Primary, Secondary and Administrator Contacts. This will be the method that OSHPD is notified of any changes in name, mailing address, phone number, and email address for each contact. Modifying contact demographic information directly changes the information on the OSHPD database.
3. Reset passwords for MIRCal users within my facility. In the event that a user misplaces or forgets their password, they will be directed to contact their User Account Administrator to have it reset. The User Account Administrator should authenticate the user prior to resetting the password and issuing a new password.
4. Unlock MIRCal user accounts. MIRCal wll lock user accounts after three (3) unsuccessful log on attempts. When the account is locked, users will be required to contact their User Account Administrator to unlock their account.

By signing this document I acknowledge reading, understanding, and agreeing to its contents.

10. USER ACCOUNT ADMINISTRATOR SIGNATURE:	**11. DATE:**

Section 2: Facility Administrator Approval *(all information is required)* *To be completed by the Facility Administrator (CEO or equivalent)*

12. FACILITY ADMINISTRATOR NAME:	**13. FACILITY ADMINISTRATOR SIGNATURE:**
14. DATE:	**15. PHONE NUMBER:**

The **original** of this completed form, for each User Account Administrator having OSHPD on-line access, shall be provided to OSHPD at the time it is prepared and signed.

Section 3: For OSHPD use only

Date Received:	Date Authenticated/Enrolled:	By:
User Name:	Note:	

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
HEALTHCARE INFORMATION DIVISION
PATIENT DISCHARGE DATA SECTION
818 K Street, Room 100
Sacramento, California 95814
(916) 323-7679 FAX (916) 327-1262

Facility User Account Administrator Agreement Definitions

Make a copy of the completed forms for your records. Mail the original(s) to:

Office of Statewide Health Planning and Development
Patient Discharge Data Section
818 K Street, Room 100
Sacramento, CA 95814

Contact Information
Call your OSHPD Analyst or (916) 324-6147
E-mail mircal@oshpd.state.ca.us

SECTION 1: MIRCal User Account Administrator Information *(All fields must be completed) --* ***To be completed by the prospective MIRCal User Account Administrator***

1. Facility Number: Provide your OSHPD assigned facility number.
2. Facility Name: Provide the name of your facility.
3. Name: Provide your full name.
4. Business Address (Mailing Address): Enter the business address where you can receive mail.
5. Unique Employee Identifier: Provide an identifier that your facility uses that uniquely distinguishes you from other employees within your organization.
6. Business Phone: Provide a phone number where you can be contacted.
7. Business Fax: Provide a fax number where you can receive faxes.
8. E-mail address: Provide an email address where you can be contacted.
9. Authentication Words: The authentication words provided may be used to identify you in the event that a password reset is required. It is important to remember this information.
   a. Provide your mother's maiden name
   b. Provide your city of birth
10. User Account Administrator Signature: If you acknowledge reading, understanding and agreeing to the contents of this document, provide your signature.
11. Date: Provide the date that the facility agreement was completed and signed.

SECTION 2: Facility Administrator Approval (*All fields must be completed) – To be completed by the Facility Administrator (CEO or equivalent). This should be the person who directs the overall management of the facility.*

12. Facility Administrator Name: Print your name
13. Facility Administrator Signature: After you have reviewed and approved the completed Facility User Account Administrator Agreement, you must provide your signature indicating approval of person to act as the MIRCal User Account Administrator
14. Date: Date of signature
15. Phone Number: Provide a phone number where you can be reached.

SECTION 3: For OSHPD Use Only

MIRCal
Medical Information Reporting for California

Designated Agent User Agreement

Please print clearly

Section 1: MIRCal Designated Agent User Information *(all information is required)*

1. DESIGNATED AGENT NAME	
2. NAME OF MIRCAL DESIGNATED AGENT USER (FIRST, MIDDLE INITIAL, LAST):	
3. BUSINESS ADDRESS (MAILING ADDRESS):	**4. UNIQUE EMPLOYEE IDENTIFIER:** ***Note: An identifier that uniquely distinguishes you within your organization.***
5. BUSINESS PHONE:	**6. BUSINESS FAX:**
7. E-MAIL ADDRESS:	
8. AUTHENTICATION WORDS: *Remember these words, you may be asked to identify yourself with this information if you call to reset your password.*	
a. *Your mother's maiden name:*	**b. *Your city of birth:***
I understand that as a Designated Agent User, I can submit data and retrieve the status of the data on behalf of a hospital. By signing this document I acknowledge reading, understanding, and agreeing to its contents.	
9. DATE:	**10. USER SIGNATURE:**

Section 2: Designated Agent Primary Contact Approval *(all information is required)*

11. PRINT NAME:	**12. DESIGNATED AGENT "*PRIMARY*" CONTACT SIGNATURE:**
13. DATE:	**14. PHONE NUMBER:**

The **original** of this completed form, for each user at a Designated Agent having OSHPD on-line access, shall be provided to OSHPD at the time it is prepared and signed.

Section 3: For OSHPD use only

Date Received:	Date Authenticated/Enrolled:	By:
User Name:	Note:	

Please Note: The Hospital Administrator at each hospital that your facility represents must complete and sign the Agent Designation Form (OSHPD 1370.3) approving a Designated Agent to submit data on their behalf.

Designated Agent User Agreement Definitions

SECTION 1: MIRCal Designated Agent User Information *(All fields must be completed) -- To be completed by MIRCal User requesting access to MIRCal.*

1. Name of Designated Agent: Provide the name of your business.

2. Name of MIRCal Designated Agent User: Provide the full name of the MIRCal user.

3. Business Address (Mailing Address): Enter the business address where you can receive mail.

4. Unique Employee Identifier: Provide an identifier that your facility uses that uniquely distinguishes you from other employees within your organization.

5. Business Phone: Provide a phone number where you can be contacted.

6. Business Fax: Provide a fax number where you can receive faxes.

7. E-mail address: Provide an email address where you can be contacted.

8. Authentication Words: *Remember these words, you may be asked to identify yourself with this information if you call to reset your password.*
   a. Provide your mother's maiden name
   b. Provide your city of birth

9. Date: Provide the date that the facility agreement was completed and signed.

10. User Signature: If you understand and agree with the responsibilities and guidelines for maintaining MIRCal security, as detailed in the user agreement, provide your signature.

SECTION 2: Designated Agent Primary Contact Approval *(All fields must be completed)* **--** *Must be completed by the Designated Primary Contact.*

11. Print Name: Print the name of the Designated Agent Primary Contact

12. Designated Agent Primary Contact Signature: When the completed information is reviewed and approved, provide your signature indicating approval of person to use MIRCal.

13. Date: Provide the date that this user agreement was approved and signed.

14. Phone Number: Provide a phone number where you can be reached.

SECTION 3: OSHPD Use Only